This Information Should Be Directed to the Management Staff of Your Agency

Bureau Talk

Missouri Department of Health

Bureau of Home Care and Rehabilitative Standards
Volume 00-3 – June 2000

Agency Changes For All Types of Providers

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Please remember when making changes within your agencies our bureau MUST be notified of any change in advance, as some changes require pre-approval by both the State and Medicare. Changes can be as minor as a phone number to major changes such as ownership or location, but any change needs to be documented and mailed or faxed to our office. **For home health branch approvals/expansions:** Medicare home health agencies wishing to add a branch location must fill out a Determination/Approval Application Questionnaire. No branch office will be recognized by HCFA without completion of this form and receiving prior approval. Our fax number is 573/751-6315.◆

HHA Change of Ownership Merger Consolidation

The Health Care Financing Administration (HCFA) has provided guidance to the State Agencies for OASIS implementation in three situations: where an HHA undergoes a change of ownership with a merger of two or more agencies; where there is a change of ownership with and without assignment of the seller's provider agreement; and where there is termination of the provider agreement.

As part of HCFA's effort to achieve broad-based improvements in quality of care furnished by home health agencies through Federal programs, OASIS is one of the most important aspects of the HHA's quality assessment and quality improvement effort. OASIS will assist agencies in improving their performance through improvement (OBQI) reports currently under development. As the individual patient assessments are linked to the individual HHA by their provider number, the OBQI reports will also be linked to the individual HHA by their provider number. It is imperative that the provider number be accurately reported on the OASIS assessments in all reports, including when HHAs undergo change of ownership, mergers, or terminations. The guidance and recommendations provided applies to all home health agencies that participate in Medicare and to HHAs that are required to meet the Medicare Conditions of Participation, including Medicaid HHAs.

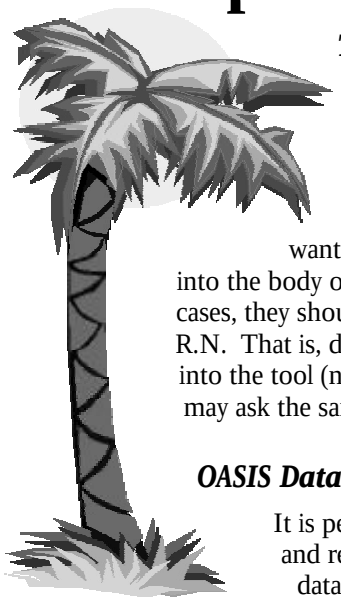
Change of Ownership – Mergers
In accordance with 42 CFR Part 489.18, the merger of a provider corporation into another corporation constitutes a change of ownership. In the case of the merger of Agency A into Agency B, Agency A's provider agreement and its associated provider number are terminated. Agency B retains its existing provider agreement and provider number.
Agency A should provide the OASIS discharge comprehensive assessment for each discharged patient prior to or at the effective date of the merger. The surviving HHA (Agency B) should provide a Start of Care (SOC) comprehensive assessment for all persons it admits after the merger at the next skilled visit after the official merger date. The SOC assessment will allow eligibility for the home health benefit to be verified and care planning for the individual to proceed under Agency B. Subsequently, the assessments for all individuals being accepted for care by Agency B will be linked to the correct provider number to enable the agency to engage in quality improvement efforts with accurate OBQI reports.

Change of Ownership with Assignment
In accordance with 42 CFR Part 489.18, when there is a change in ownership and the new owner accepts assignment of the existing provider agreement, the new owner is subject to all the terms and conditions under which the existing agreement was issued, including compliance with the comprehensive assessment of patients condition of participation. The provider number remains the same if the new HHA owner accepts assignment of the existing provider agreement. The new owner is responsible for continuing to complete updates to the comprehensive assessment at the next scheduled time points.

Change of Ownership without Assignment
In accordance with 42 CFR Part 489.18, when there is a change in ownership and the new owner rejects assignment of the provider agreement, the provider agreement and provider number of the former owner should be terminated. The HHA that is terminating its provider agreement and provider number should provide an OASIS discharge comprehensive assessment for each patient subject to OASIS standards prior to the effective date of the termination, according to 42 CFR 484. The new HHA will not be able to participate in the Medicare program without going through the same process as any new provider, which includes an initial survey. The HHA should meet all the federal requirements, including applicable OASIS requirements as specified in the regulations, for all persons it accepts for care in order to participate in the Medicare program. This means that the HHA should provide a new SOC comprehensive assessment at the first skilled visit once it becomes Medicare-approved. In addition, updates to the comprehensive assessment should be provided at the other OASIS time points, in accordance with 42 CFR Part 484, for all patients of the former owner it accepts for care.

Voluntary Terminations
In accordance with 42 CFR Part 489.52, a Medicare approved HHA may voluntarily terminate its provider agreement by filing a written notice of its intention to the State Agency who, in turn, notifies the Regional Office. HCFA recommends the HHA that is terminating its provider agreement should provide a discharge comprehensive assessment for each patient prior to the effective date of the termination. ◆

OASIS Update



Therapy Only Patients

There has been some misunderstandings related to the Start of Care comprehensive assessments with OASIS items incorporated that are completed by a therapist for therapy only cases. The following is guidance received from HCFA for this type of assessment. "Comprehensive assessment tools should not be made up of pieces and parts. There should be a complete assessment tool that includes information the agency wants to collect based on its patient population along with the OASIS data items incorporated into the body of the assessment tool. If an HHA wants an assessment tool more suited for their therapy cases, they should take the same approach they do for the assessment tool developed for completion by the R.N. That is, develop an assessment best oriented for the therapy patient, incorporating the OASIS items into the tool (not tacking them on the beginning, middle or end.) This avoids the situation where the HHA may ask the same question two different ways and get two different answers." ◆

OASIS Data Entry Errors

It is permissible, with certain OASIS data entry errors to unlock the record, make the correction and re-lock the record. Due to the frequent questions received regarding the correction of OASIS data, the current correction policy has been summarized for easier utilization by the agency staff.

Three types of corrections an HHA may need to make:

1. **Assessment submitted to the state and was rejected.**
   A. HHA can unlock the assessment.
   B. Make the necessary changes
   C. Re-lock the assessment
   D. Re-submit to the state
2. **Assessment submitted and accepted by state but need *key field* changes.**
   A. HHA should unlock and correct its copy of the record.
   B. No resubmission to the state is made.
   C. The HHA must contact the state and request correction of the field so that all data at the HHA and state database is consistent.
   D. The correction field is NOT incremented.

   Only the patient identifier fields on that assessment are updated. No other assessments corresponding to that patient are updated.

   The HHA **CANNOT request a change to the reason for assessment (**RFA**) once it has been transmitted to the state (even though it is considered a key field to uniquely identify the assessment). If the HHA has submitted the wrong RFA, it must: submit another record with the correct MO 100.
3. **Assessment submitted and accepted by the state but need *non-key field* changes.**
   A. HHA will make a new copy of the record (Correction option #3 in Haven)
   B. Revise the necessary non-key fields in the new assessment record.
   C. It will increment correction number by one in the new assessment record (done automatically in Haven software).
   D. Lock the new record (lock date should be updated)
   E. Submit the corrected record
   F. The correction number field will be incremented ◆

Change in Payer Source Scenario:

An agency has been seeing a patient and billing insurance. In April the insurance was cancelled and Medicare became effective but no one was aware of this. Two months later the HHA finds out they should have been billing Medicare. Do they do a DC assessment to reflect the last date of the **old** pay source and a new SOC to reflect the Medicare pay source even though it is two months late?

Answer:
The HHA should have data on file that they can refer to since they were collecting (but not encoding or submitting) non-Medicaid/non-Medicare OASIS data. If that is the case, then a Medicare patient would need an assessment that documents a start of care date that **corresponds** with Medicare billing.

A discharge should be done and a SOC assessment completed, encoded and transmitted along with any subsequent assessments required based on the new SOC. ◆

Hospital Discharge Question:

If there is a policy to discharge a patient in a hospital after a certain amount of time (ex: 7 days) will Haven allow a new SOC since there was no OASIS discharge?

Answer:
Yes, Haven will allow a new SOC even though no discharge OASIS assessment was done. Haven will **accept** a SOC **after** a transfer to inpatient facility whether #6 (hold) or #7 (discharge). ◆

Family Care Safety Registry and Access Line

The passage of House Bill 490 during the 1999 Legislative Session created the Family Care Safety Registry and Access Line and gave the Department of Health, in coordination with the Departments of Social Services and Public Safety, the task of establishing the registry by January 1, 2001.

What is the Family Care Safety Registry and Access Line?
The Family Care Safety Registry and Access Line will help protect children and elderly in this state by providing background screening information on certain child-care and elder-care workers and licensure status information on licensed child-care and elder-care providers. The registry will contain information on child-care workers' and elder-care workers' backgrounds and child-care and elder-care providers through:

- State criminal background checks conducted by the Missouri State Highway Patrol
- Child abuse/neglect records, maintained by the Division of Family Services
- The Employee Disqualification List, maintained by the Division of Aging
- Child-care facility licensing records, maintained by the Department of Health
- Foster parent, residential care facility, and child placing agency licensing records, maintained by the Division of Family Services
- Residential living facility and nursing home licensing records, maintained by the Division of Aging

Who will be required to register in the Family Care Safety Registry?
Any person hired on or after January 1, 2001, as a child-care worker or elder-care worker, as defined in Section 210.900, RSMo, is required to make application for registration in the Family Care Safety Registry within 15 days of the beginning of employment

What is the penalty for not registering?
Any person employed as a child-care or elder-care worker who fails to submit a completed registration form to the Family Care Safety Registry as required by Sections 210.900 to 210.936, RSMo, is guilty of a class B misdemeanor.

How is background information requested from the Family Care Safety Registry?
A person will be able to call a toll-free telephone number to request background information on individuals registered in the Family Care Safety Registry. A system is also being developed that will allow employers to submit multiple inquiries on employees or prospective employees.

Who can receive background information from the Registry?
A person can request background information for employment purposes only. Employment purposes include direct employer-employee relationships, prospective employer-employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child- or elder-care setting. Any person who uses the information obtained from the registry for any purpose other than employment purposes is guilty of a class B misdemeanor.

What information will the Family Care Safety Registry disclose?
Disclosure of background information on an individual registered in the Family Care Safety Registry will be limited. Upon receiving an inquiry, a registry worker will first confirm whether the individual is listed in the Family Care Safety Registry. If the individual is listed, the registry worker will then disclose whether the individual's name is listed in any of the background checks and if so, which one.

Specific background information will only be disclosed after the registry has received a signed request with the inquirer's name, address and reason for requesting the information.

Registrants will be notified each time they are the subjects of an inquiry to the registry. The notification will contain the name and address of the person making the inquiry.

How can I obtain additional information on the Family Care Safety Registry?
More information on how the Family Care Safety Registry and Access Line will affect providers and their employees will be included in subsequent issues of *Bureau Talk*.

Comments and questions may be sent to the Family Care Safety Registry, Missouri Department of Health, P.O. Box 570, Jefferson City, MO, 65102 ◆

Outpatient Physical Therapy (OPT)

Medicare OPTs located within another facility, such as a nursing home, must meet all requirements and regulations. This includes exit signs, fire drills, fire extinguishers, two persons on duty on the premises, patient records stored within the OPT, easily accessible exits from the building, etc. Also during survey activity to such OPTs, the surveyor will need to see verification the OPT received from the Division of Aging (DOA) showing they have knowledge the OPT is operating within a facility licensed and certified by DOA. Always remember, an OPT operating within another facility is no different than a self-standing OPT.

MISSOURI DEPARTMENT OF

HEALTH

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